WEST SHORE UROLOGY, PLC
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____ Date of Birth: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHIC RECORDS BE SENT TO/RECEIVED FROM OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

No Information to be released _____ (please initial)

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

Cell Phone Confirmation **Any of the Above**
Home Phone Confirmation
Work Phone Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Confirmation **Any of the Above**
Home Phone Confirmation
Work Phone Confirmation

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

Mail Phone Message

None (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____

Revised 9-13

WEST SHORE UROLOGY, P.L.C.
YEARLY AUTHORIZATIONS

PATIENT NAME _____DATE OF BIRTH_____

PAYMENT AGREEMENT- I understand West Shore Urology, P.L.C. will bill for most services provided to me. If I do not have insurance, I agree to pay West Shore Urology, P.L.C. for all charges for services provided to me as requested. If I have health insurance which covers services I received, I understand I am responsible if, for some reason, West Shore Urology, P.L.C. is not paid by insurer for the services I received, unless health insurer has an agreement with West Shore Urology, P.L.C. which prohibits billing me for services. I agree to pay West Shore Urology, P.L.C. the amount of any charges not covered by or disputed by the insurance, worker's compensation carrier or employer. I understand for any unpaid balance, West Shore Urology, P.L.C. will use the services of a third-party collection agency to collect any outstanding balance.

MEDICAL RELEASE- I hereby authorize West Shore Urology, P.L.C. to disclose any medical records or other information pertaining to my treatment, hospitalization or outpatient care to my insurance company, employer or acting intermediary. A photocopy of this authorization shall be valid as the original.

INSURANCE AUTHORIZATION- I also authorize payment of medical benefits to be sent directly to West Shore Urology, P.L.C. (Tax ID# 38-1969372) for any services rendered. I have read this form (or have had it read to me) and I understand it. I agree that by signing this form I am bound by what it says whether I am the patient or someone acting on the patient's behalf.

HIV/HEPATITIS TESTING- For the protection and proper treatment of patients, medical staff and health care personnel, I understand that I may need to be tested for human immunodeficiency virus (HIV) and Hepatitis if a health professional or office associate sustains a percutaneous (needle stick), mucous membrane or open wound exposure to my blood or other body fluids.

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

Revised 9-13